

CASAS ADOBES PEDIATRICS, LLC
(A DIVISION OF ARIZONA COMMUNITY PHYSICIANS)

PATIENT REGISTRATION FORM

Please print legibly and complete all information. Thank you.

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Patient Last Name		First Name		Middle	Date of Birth
Sex	Social Security Number	Marital Status	Student		Primary Care Physician
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Single <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> H. Bianchi <input type="checkbox"/> C. Swanson	
Parent/Guardian Last Name		First Name		Middle	Relationship to Patient
					<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other
Patient Address / Street			City	State	Zip Code
Phone: Home		Parent's work		Cellular	
Emergency Contact	Name	/	Phone	/	Relationship
<input type="checkbox"/> Same as above		<input type="checkbox"/> Other: _____			

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PRIMARY INSURANCE COMPANY		ADDRESS TO MAIL CLAIMS			
GROUP NUMBER		ID/POLICY NUMBER		CO-PAY	
PRIMARY SUBSCRIBER NAME		DATE OF BIRTH		EFFECTIVE DATE	
Relationship of Patient to Subscriber		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Foster Child <input type="checkbox"/> Step Child			
SECONDARY INSURANCE COMPANY		ADDRESS TO MAIL CLAIMS			
GROUP NUMBER		ID/POLICY NUMBER		CO-PAY	
PRIMARY SUBSCRIBER NAME		PRIMARY SUBSCRIBER DATE OF BIRTH		EFFECTIVE DATE	

By signing this form, I hereby authorize and request payment of medical benefits for services and/or supplies rendered to me be paid directly to ARIZONA COMMUNITY PHYSICIANS, P.C. or the authorized representative. I authorize release of any medical record or other information necessary to process claims, related to such service, to government benefit programs or other medical insurance payers. I further permit a copy of this authorization to be used in place of the original. By signing, I understand that regardless of any available insurance plan or program, I am financially responsible for any incurred charges.

The effective period of this authorization is from today's date to a future date, when I am no longer a patient of the Arizona Community Physicians, P.C. group or deceased.

Patient or Guardian Signature: _____ **Date:** _____